The Impacts of Resident-Centered Care on Conflicts in Nursing Homes

EUN KYUNG LEE
ERIK YOUNG
University of Illinois at Urbana-Champaign

Abstract

As the value in changing work practices has been recognized along with a shift to the new paradigm of customer-patients, many health care delivery organizations have been engaged in organizational initiatives to improve care quality. In this paper, we focus on resident-centered care (RCC) practices in nursing homes and examine how organizational practices affect organizational conflicts among employees and conflicts with resident families. In results, we found positive evidence that resident-centered care practices are negatively related to task conflicts among employees and that to the extent to which nursing home organizations implement RCC practices, employees experience less conflict with residents' families over personal and resident care issues. Implications of these results are provided for future research on high performance work systems (HPWS) and conflict as well as for practice.

Introduction

Among the most pervasive and enduring symbols of health care professions is a basic tool, the stethoscope. The introduction of this technology in 1817 allowed for more precise medical information to be gained; however, this added precision came at the cost—not wholly unintended at the time—of more impersonal and distant delivery of care (Starr 1982). Although it was impossible to foresee at the time, this invention and its implications are an apt microcosm of larger scale developments in health care that subsequently took place. Over the course of the century following, the balance of social forces shifted expectations surrounding health care delivery, and this shift, along with advances great and small—but always continuous—in medical technology merged to effectuate the inevitable shift in organizational and employment systems. This parallels the model hypothesized for manufacturing work and organizations (Piore and Sabel 1984).

Thus, when viewed in retrospect from an industrial relations perspective, the social forces that gave rise to the modern paradigm of health care consumerism are at once obvious. The ascension of large, modern, and impersonal organizations delivering efficient, if conspicuously sterile, services is viewed not as a planned or organized drive, but rather as the inevitable end result of shifts within a system of interlocking markets (Rosenberg 1987). Communities increasingly shifted away from small, intimate settings, and institutions had to conform. Health care delivery, which increasingly served larger swaths of population while also needing to continuously manage its investments into new technologies, developed over time the need to implement bureaucratic administration. Work associated with health care delivery therefore also shifted along the same lines; physicians began treating patients within the walls of organizations rather than their homes—with greater clinical accuracy, but less personal closeness (Rosenberg 1987). As this organizational paradigm crystallized, institutional pressures reinforced the hierarchies in place and created incentives to protect investments. Thus, the modern archetype of health care delivery relies on the needs, goals, and values of key stakeholders in the

Author's address: School of Labor and Employment Relations, 504 E. Armory Avenue, Champaign, IL 61820

institution—third-party payers who fund the institution and principal medical staff who provide vital services; this is not unlike the model of publicly traded organizations in which managers seek to maximize shareholder value without regard to other stakeholder needs or preferences (Starr 1982, Rosenberg 1987).

However, just as organizations in manufacturing (cf. Ichniowski, Shaw, and Prennushi 1997) and service types apart from health care (Batt 2002) have recognized the value in changing work practices, some health care delivery organizations have recently recognized that shifts in the organization of work, which reflects different organizational values that are precipitated by new turns in the gears of societal pressures, may create newfound increases in performance (Avgar, Givan, and Liu 2009). Wide dispersion of new technologies has allowed greater access to information about health care, and individuals are now more knowledgeable and vocal in their preferences than at any previous time (Ford and Fottler 2000). As a result, a new institutional paradigm is emerging in which health care delivery recognizes this democratization of medical knowledge, places value on the health care experience for consumers, and focuses delivery on the needs and preferences of those seeking care for themselves and their families (Lauver et al. 2002, Wolf et al. 2008).

One important environment being given increased attention within health care is the nursing home. The close, chronic nature of contact with residents makes it a particularly prominent context for examining the impacts of innovative and personalized health care delivery (Rantz et al. 1998). Empirical examinations of these effects are in their infancy, however; in fact, consensus has yet to be established as to which variables may best illustrate the quality of nursing home experience for residents. There is also a paucity of evidence regarding the effects changes in nursing home work practices have on the caregiving employees.

Our study seeks to fill these gaps by examining the link between implementation of resident-centered work practices and conflict. We view conflict to be an important relational phenomenon—one that serves to illustrate the quality of nursing home functioning (Rantz et al. 1998, Nelson and Cox 2003) as well as nature of functional professional relationships developed between employees (Heglund 1990, De Dreu and Beersma 2005).

Resident-Centered Care in Nursing Homes

These are a part of a growing trend that finds many health care organizations expending considerable efforts in satisfying one of their key stakeholders—patients, by meeting their needs as a customer of the total health care experience as well as their clinical needs. The effort relates to a shift toward a new paradigm highlighting the view that the "patient is a customer of a health care experience that is more than a good clinical outcome" (Ford and Fottler 2000:23). Bergeson and Dean (2006) emphasize that hospitals should respond to their consumers with personalized, high-quality care and service excellence to thrive in the era of health care consumerism. In a similar line, Ford and Fottler (2000) proposed 10 principles of the new paradigm by which health care organizations might enhance their service capabilities and gain a competitive advantage. These include developing a customer-focused culture, training and motivating employees, designing an attractive service environment, and committing to continuous improvement.

In related efforts to support a shift to a new paradigm of customer-patients, organizational initiatives for quality care have been noted and implemented in the hospital setting. Many researchers addressed the crisis in quality of patient care (cf. Kohn, Corrigan, and Donaldson 2000; Aspden, Wolcott, Bootman, and Cronenwett 2007), and examined a variety of different work and patient care delivery reorganization initiatives to improve quality (Lee and Alexander 1999; Aiken, Clarke, and Sloane 2002; Wolf et al. 2008).

In line with the changing mode of patient care delivery, it is important to note that *patient-centered care* (PCC) implementations seek to change organization practices as well as the underlying philosophy of care (Avgar, Givan, and Liu 2009). Much attention has been paid to PCC dimensions and impacts on various organizational outcomes since the Institute of Medicine listed it as one of the six measures central to rebuilding the U.S. health system (Institute of Medicine 2001). Quality is often defined as providing the right care in the right way at the right time, but a patient-centered vision would make quality focused toward patient preferences—the care that a patient feels he or she needs, in the manner the patient desires, and at the time the patient desires (Davis, Schoenbaum, and Audet 2005). Therefore, the core notions of patient-centered care would be to depart from the physician- or institution-centered model and instead to enlarge patient engagement and coordination of care for the best quality of care (Avgar, Givan and Liu 2009).

There is considerable consensus about the notion and underlying logic of PCC, and there exist two common threads. One is to make health care delivery more responsive to patient needs (often by increasing the involvement of a patient in the care process), and the other is to modify or create new organizational work arrangements to deliver quality care. In other words, PCC implementation focuses on increased understanding of patients' needs, preferences, beliefs, and expectations by allowing for more direct patient input and reinforcement of this personalization through work organization that stresses this tailoring of needs (Lauver et al. 2002). Restructuring of workplace practices, such as improved coordination between different organizational units, would be required for best quality care to patients in PCC (Avgar, Givan and Liu 2009). In sum, PCC is intended to shift fundamental aspects of how health care organizations operate and provide care for patients (Avgar, Givan and Liu 2009).

A specific example of the change occurring in health care organizations generally is the combined effort by consumers, professionals, and policymakers currently being undertaken to improve quality of care and quality of life in American nursing homes (Bostick 2004). Several attempts to understand the specific aspects of nursing home quality have been put forth. For instance, Glass (1991) suggested a model with four major dimensions of quality: staff intervention, physical environment, nutrition/food service, and community relations. Rantz et al. (1998) conducted an exploratory qualitative study in a Missouri nursing home. The multidimensional model that emerged from their analysis mirrors the elements proposed by Glass in its major respects; however their analysis indicated that two core variables proved to be most important in driving quality perceptions: interaction of staff with residents and families, and odor (an important proxy for physical environment). These models remain highly theoretical and without the benefit of rigorous empirical testing. Also, while some studies examined the association between a lone organization practice and nursing home care quality (for example, see Bostick 2004), to our knowledge, the effect of implementing a comprehensive system of resident care quality in nursing homes has not been suggested nor tested.

Work Practices and Organizational Outcomes

At its core, resident-centered care (RCC) is a human resource practice initiative aimed at gaining performance benefits. While there is still a great amount of heterogeneity in how the practices are defined in the health care setting (Garman et al. 2009), most prevailing labels for systemic implementations would be *high-performance work practices* (HPWP) or *high-performance work systems* (HPWS). Two important links can be made with this literature: organizational values as a driver for implementation, and the organizational outcomes associated with subsystems that tend to be included in HPWS implementation.

Strategic implementation of employment initiatives aimed at achieving performance gains does not always carry the same underlying motivations. Organizations vary in their stimulus for employing HPWS, even when their ultimate general goal of improved organizational effectiveness is shared. A nascent trend holds that organizational values—a key component underlying the adoption of RCC and of innovative health care workplace practices generally—have been found to be a key driver of adoption of HPWS (Osterman 1994, Bae and Lawler 2000). Two empirical studies have found a positive impact of organizational values on adoption of HPWS. Bae and Lawler (2000:504) state that "high-involvement HRM [human resource management] strategy starts with management philosophies and core values that emphasize the significance of employees as a source of competitive advantage." The authors found a significant positive relationship between organizational values on HRM and the adoption of high-involvement HR practices in a sample of South Korean firms. In a large sample of American organizations, Osterman (1994) found organizational values to be the strongest predictor of the adoption of innovative work practices.

The main argument underlying HPWS is that they enable organizations to develop skillful, motivated, and committed employees, who can create superior value for organizations (Pfeffer 1994). Huselid (1995) argued that HPWS enhance employee skills and motivation and provide a work environment where the employees can best utilize their skills and discretion to achieve organizational goals. Using a cross-industry sample of 968 firms, he found that HPWS reduce workforce turnover and increase organizational productivity and financial performance.

It is important to note that an emerging body of empirical research indicates that HPWS have an effect on individual employee attitudes and behavior. For example, Macky and Boxall (2007) conducted a study of employees in New Zealand and found that HPWS increased affective commitment, trust in management, and job satisfaction. Agarwala (2003) also found HPWS to significantly predict managerial employees' organizational commitment. Applebaum, Bailey, Berg, and Kalleberg (2000) conducted a large study of employees in the steel, apparel, and—most significantly for our purposes—medical technology industries, and found that employees' experiences of individual HPWS practices positively influenced their organizational commitment, job satisfaction, stress, and trust in the organization.

These findings provide depth to the notion that employment initiatives in health care are analogous to HPWS. Garman et al. (2009) provide several descriptions of subsystems of HPWP specific to health care settings, which naturally have implications for RCC. Their model included four subsystems: organizational engagement, staff acquisition/development, frontline control/freedom to challenge, and leadership alignment/development.

Staffing in particular has been found to be of critical importance in RCC. It has been assumed that the quality of nursing home care relies heavily on the type and number of nursing staff (Bostick 2004), and there is some empirical evidence indicating that nursing staff have a direct influence on the quality of specific resident outcomes (Kayser-Jones 1997, Kayser-Jones and Schell 1997). Bostick (2004) emphasized the importance of staffing in nursing homes by contending a direct link between insufficient staffing and various physical and behavioral problems of residents (i.e., weight loss, incontinence, pressure ulcers). Often, nursing homes can be tempted to minimize costs at the expense of quality care by substituting lower paid nonprofessional staff for higher paid professional staff. However, this lacks important historical perspective in that the professionalization of nursing is viewed as the most vital driver in reshaping the patient health care experience (Rosenberg 1987). Thus, nursing homes need to maintain sufficient staffing levels as well as high commitment in order to provide the quality of care standards residents might expect with RCC. In addition, it is important to develop the workforce through continuous training. Bostick (2004) pointed out that today's nursing facilities experience increased resident acuity level, which often leads to higher workload for staff, greater strain on staff resources, and reduced quality of nursing home care. A nursing home's investment in developing high skilled staff is thus another means to offer high quality resident care.

Lastly, important studies have begun to emerge linking HPWS within nursing home facilities. Eaton (2000), in a qualitative study of 20 nursing home facilities, identified three typologies for nursing home care, each with characteristic workplace assumptions and work organizations—and thus differing outcomes. A "regenerative" model engendered a focus on resident choice and preference as well as an effort to redefine the facility as more of a community than a health care delivery vehicle. Thus, the work arrangements for employees are unique among other types of nursing homes—workers engage in a greater variety of tasks, which means they must be offered more cross-training, and their efforts are better defined as as-needed support rather than as administrators of care. This model, while effective in its own ways, is relatively rare and distinctive. The two other models identified in Eaton's work were found to be much more dominant: the low-quality care model, which made up the bulk (about 70 percent) of subject locations, and the high-quality care model. These models were described in much more familiar terms for organizational scholars. The low-quality care model was characterized by traditional, hierarchical features for line employees, such as low wages, little opportunity for voice and input, and high amounts of task supervision. The high-quality model, which was characterized as akin to a HPWP model, offered higher wages and a more adaptive team-based approach. This model resulted in lower annual turnover rates for these organizations compared with the low-quality care facilities.

We believe the current study will add to the growing body of work looking into employment practice systems in the nursing home context. We believe further that it contributes to HPWP literature by adding a context-specific argument and added empirical evidence.

Impacts of RCC on Conflict

Organizational outcomes examined in the studies addressing the impacts of work practices in health care organizations tend to view patient mortality rates as the most relevant dependent variable (for example, see West et al. 2002 or West et al. 2006). However, it has been noted that additional outcomes, such as patient satisfaction, employee outcomes, and other measures of quality of care, should be incorporated (Avgar et al. 2009). For example, Mead and Bower (2000) proposed that the effect of patient-centered care is mediated by the quality of the practitioner–client relationship. We believe that conflicts employees experience with other employees as well as with resident families are important variables to consider in understanding the relationship between resident-centered care practices and organizational outcomes.

In previous human resources and organizational behavior research, conflict has been extensively studied with respect to its impacts on individual, team, and organizational outcomes (Amason and Schweiger 1997, De Dreu and Van Vianen 2001, Jehn and Mannix 2001, De Dreu and Weingart 2003, De Dreu and Beersma 2005). Despite the voluminous research that has been done, a debate still exists as to whether organizational conflict is beneficial or detrimental to organizational functioning. Specifically, task conflict has been often associated with positive effects in that it may increase group members' tendency to analyze task issues and thus stimulate the processing of task-relevant information (Amason and Schweiger 1997; Janssen, Van de Vliert, and Veenstra 1999). Relationship conflict, on the other hand, has been negatively related to performance and individuals' satisfaction because it distracts people from task efforts (De Dreu and Weingart 2003; Jehn 1995, 1997). However, the notion that task conflict may benefit team performance or decision quality has been also challenged by recent meta-analytic results and critical review of previous evidence (De Dreu and Weingart 2003, De Dreu 2008).

Consequences of conflict in nursing home settings may have greater impact compared with traditional types of organizations because organizational conflicts among employees can be transferred to residents in some way. In other words, nursing home employees experiencing conflicts may not only experience individual negativity such as burnout, absenteeism, or job dissatisfaction, but they may also act out their frustrations through such actions as resident abuse (Hegland 1990). More importantly, conflicts between employees and residents would impede residents' satisfaction with the care and nursing home.

In this study, we focus on two types of conflict that may arise in nursing homes: task conflict among employees and employee conflict with resident families. Task conflict refers to the conflicts in the unit between peers, supervisors and employees, and employees and supervisors outside their unit over resident care issues. In the health care setting, resident care is the dominant task-associated focus (Avgar 2009), so we labeled conflicts among employees on resident care issues as "task conflict." However, it is distinguished from task conflict described in a general organizational setting (Jehn 1995) by its narrowed focus, in our study exclusive to resident care issues (e.g., medication, surgical intervention, or care planning). Moreover, we believe task conflicts regarding resident care issues are not functional, as they might sometimes be in other organizational settings. That is, task conflict in other settings may be viewed as a facilitative process generating creative or higher quality ideas and solutions (e.g., Amason 1996, Amason and Schweiger 1997); however, disagreements over resident care issues can often result in delay of care, let alone result in personal tensions and emotional conflicts (Simons and Peterson 2000). Therefore, we view task conflict as basically negative to nursing home organizations.

Furthermore, employees will likely experience fewer conflicts over resident care issues when nursing homes implement resident-centered care practices. RCC aims to make employees place greater value on resident care and agree on such shared goals. When most employees in a nursing home accept the values imposed by RCC and try to behave in a way that reinforces such value, they would be less likely to experience dissension with regard to resident care–related judgments. Instead, employees are likely to agree on means that maximize benefits for residents. That is, when nursing staffs share one common decision rule that only takes account of residents' well-being and benefits—and that rule is held above any other consideration—employees will experience less task conflict regarding resident care issues. Based on this line of reasoning, we advance the following hypotheses regarding the impacts of RCC on task conflicts among employees in nursing homes.

Hypothesis 1: RCC practices will reduce the task conflict over resident care issues employees experience in their unit with supervisor.

Hypothesis 2: RCC practices will reduce the task conflict over resident care issues employees experience in their unit with peers.

Hypothesis 3: RCC practices will reduce the task conflict over resident care issue employees experience with other units.

Conflict with resident families is a specific form of dysfunction of nursing homes. Nelson and Cox (2003) found the roots of family and staff conflict to be in resident families' guilt and negative affect about leaving the resident to a medical institution. Such negative emotions make the resident families more sensitive to and aggressive with frustrations stemming from perceptions of difficult staff or a nursing home institutional culture that does not allow family or resident influence. Furthermore, resident families are more likely to be truculent with nursing home staffs if they perceive low quality care. If such perceptions exist, we believe conflict is more likely to occur.

We expect RCC practices to reduce the amount of conflict employees experience with resident families for several reasons. First, organizational commitment to RCC and employee participation in organizational initiatives are meant to change the culture of a nursing home from institution oriented to resident oriented. Nursing home employees become committed to delivering high quality care to residents overall, and they try to become more attentive to emotional and care needs. However, employee commitment to RCC does not by itself eliminate all potential problems with resident families. There should also be an appropriate level of professional staff who can deal with the demands or needs of residents. RCC implementations focused on sufficient staff and highly committed employees—through decreased use of agency staff—will support organizational efforts to provide quality care to residents and will in turn help prevent conflicts between employees and resident families. Finally, training is considered one of the most important conflict prevention strategies (Nelson and Cox 2003). As employees become more aware of how to deal with conflicts (or at least not to overreact), resident rights, and the causes of resident resistance and family stress, they can develop tolerant attitudes in dealing with issues of residents and resident families (Hudson 1992). In sum, adequately trained employees are likely to have enhanced interpersonal skills to manage rough situations as well as serve the needs of residents in a professional way. We offer the following hypotheses regarding conflict with resident families.

Hypothesis 4: RCC practices will reduce the conflict with families of residents over personal issues.

Hypothesis 5: RCC practices will reduce the conflict with families of residents over the way work is done.

Hypothesis 6: RCC practices will reduce the conflict with families of residents over resident care issues.

Methodology

Data

We used survey data collected as part of a large research project in nursing homes. Interviews lasting approximately 30 minutes were administered to employees in 20 nursing homes in New York state. We excluded from the survey administrators and supervisors who were not in regular contact with residents and focused on direct caregivers (RNs, LPNs, CNAs, and allied professionals). Our response stands at approximately 50 percent, with 1,241 completed interviews.

Independent Variables

Resident-centered care. The measurement of RCC incorporates measures for the five organizational work arrangements: 1) organizational commitment to RCC ("This nursing home is committed to supporting resident-centered care"); 2) employee participation in RCC ("Administration at this nursing home encourages all employees to participate in resident-directed care"); 3) focus on training ("My nursing home places a strong emphasis on training"); 4) use of agency staff ("My nursing home has many agency employees"; reverse coding); 5) sufficient staffing ("My nursing home has sufficient staff to provide good quality of care to residents"). A 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) was used for each item. We used an aggregated measure for overall RCC.

Dependent Variables

Task conflict. This variable includes resident care conflicts from three different referents. The items asked respondents about the level of patient care conflict they experienced in their unit between peers, supervisors and employees, and employees and supervisors outside their unit (sample item: "For co-workers in your unit, how would you rate the degree to which there are disagreements over resident care issues"). Three types of task conflict are called "resident care conflict with supervisor," "resident care conflict within the unit," and "resident care conflict with other units." A 4-point Likert scale (1 = not at all, 4 = large extent) was used for each item.

Resident conflict. This variable measures conflicts with resident families. It includes three types of conflicts—conflict over personal issues, conflict over the way work is done, and conflict over resident care issues. A 4-point Likert scale (1 = not at all, 4 = large extent) was used for each item.

Control Variables

We include a number of control variables in the analysis for individual demographic factors, individual level employment status, and union membership because these are likely to have an effect on employee attitudes and perceptions. They are age (in years), gender (0 = female, 1 = male), education (1 = less than high school, 2 = high school degree or equivalent, 3 = some college, but no degree, 4 = associate degree, 5 = bachelor's degree, 6 = master's degree, 7 = doctorate), tenure (in years), employment status (1 = full-time, 2 = part-time), union membership (0 = no, 1 = yes), professional affiliation (1 = CNA, 2 = LPN, 3= RN, 4 = allied professional), and nursing home facility.

Results

Table 1 reports the means, standard deviations, and correlations for all variables used in the study. The five RCC practices are significantly and positively correlated with each other. In addition, most of resident centered care practices are negatively correlated with task conflicts and resident conflicts at a significant level. It is also worth noting that task conflicts among employees are significantly and positively correlated with different types of conflicts with resident families. These positive relationships between task conflicts and resident conflicts may indicate positive interactions between employee and resident outcomes, such that employees' conflicts roll over to conflicts with the residents and their families.

Tables 2 and 3 present results of regression analyses to test the effect of RCC on organizational conflicts among employees and conflicts with residents. Hypotheses 1 through 3 predict that RCC reduces task conflicts that employees experience with supervisors, within the unit, and with other units. As seen in Table 2, RCC did significantly reduce resident care issue conflicts among employees, thus providing support for the hypotheses. However, the impacts are limited to a different set of RCC practices for different conflict types. In specific, focus on training (β = -.072, p < .05; β = -.152, p < .01) and less use of agency staff (β = -.125, p < .01; β = -.148, p < .01) significantly reduce conflict with supervisor and conflict within the unit. On the other hand, for conflict with other units, less use of agency staff (β = -.136, p < .01) and sufficient staffing (β = -.080, p < .10) had a significant negative impact. Therefore, our results support hypotheses 1 through 3, but the relationships between RCC and conflicts are found with only two or three practices.

TABLE 1
Means, Standard Deviations, and Correlations for All Study Variables

4	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Control variables																		
1. Nursing home facility																		
2. Age	47.8	10.6	-0.03															
3. Gender			0.034	-0.05														
4. Education			0.037	-.116**	.112**													
5. Tenure	7.91	7.54	-0.01	.502**	-0.01	-.151**												
6. Employment status			.083*	.199**	0.014	.118**	-.271**											
7. Union member			-.118**	.092**	-0.06	-.507**	.249**	-.230**										
8. Professional affiliation			0.022	-0.06	.075*	.675**	-.157**	0.054	-.665**									
Resident-centered care																		
9. Nursing home resident-centered care	4.26	0.68	-.139**	-0	-0.01	-0.02	-0.02	-.071*	0.014	-0.03								
10. Admin support resident-directed care	4.2	0.8	-.126**	0.042	-0.01	-0.03	-0.06	-0.03	-0.02	-0.02	.511**							
11. Strong emphasis on training	3.85	1	-.121**	0.051	-0.04	-.102**	-0	-0.03	0.047	-.107**	.458**	.457**						
12. Nursing home lots of agency staff	3.09	1.21	.131**	0	0.062	-0.02	0.021	0.013	0.059	-0.03	-.117**	-.081*						
13. Nursing home enough staff quality care	3.61	1.19	-.158**	0.037	-0.03	-.122**	-0.03	-0.01	0.059	-.116**	.373**	.304**						
Task conflict																		
14. Resident care issues-with supervisor	1.97	1.07	-0.03	-0.06	-0.06	-0.01	0.013	-0.01	0.053	-0.01	-.128**	-.078*	-.101**					
15. Resident care issues-within unit	1.98	1.08	-0.05	-0.06	-0	-0.03	0.049	0.031	0.038	-0.04	-.074*	-0.06	-.107**	.609**				
16. Resident care issues-with other units	1.97	1.04	-0.06	-0.02	-0.07	-0.01	0.026	0.02	0.012	0.006	-.135**	-.101**	-.147**	.659**	.648**			
Resident conflict																		
17. Personal issues with families	1.97	0.99	-.075*	-0.03	-0.05	0.002	0.036	-0.06	0.037	0.015	-0.03	-.092**	-.068*	.425**	.345**	.424**		
18. How to get work done with families	1.96	1.01	-0.05	-0.05	-0	0.015	0.006	0.021	0.012	0.017	-0.05	-.066*	-.093**	.518**	.428**	.512**	.665**	
19. Resident care issues with families	1.99	1	-0.04	-.069*	-0.02	0.041	-0.02	0.004	-0.03	.078*	-.075*	-.069*	-.106**	.578**	.461**	.563**	.631**	.736**

* $p < .05$; ** $p < .01$.

TABLE 2
Regression Analyses for the Effects of RCC on Task Conflict

	Task conflict					
Variable	With supervisor		Within the unit		With other units	
Control variables	SE B	B	SE B	B	SE B	B
Age	0.004	-.007†	0.004	-.011**	0.004	-0.004
Gender	0.116	-.196†	0.118	0.025	0.117	-.211†
Tenure	0.005	0.004	0.005	.016**	0.005	0.003
Employment status	0.083	-0.008	0.084	0.102	0.084	0.018
Union member	0.121	.329**	0.122	.227†	0.125	.271*
Resident-centered care						
Nursing home RCC	0.056	-.079**	0.057	-0.069	0.057	-.104†
Administration support for resident-directed care	0.048	0.018	0.049	0.025	0.049	-0.037
Strong emphasis on training	0.038	-.072*	0.038	-.152**	0.028	-0.01
Less use of agency staff	0.029	-.125**	0.029	-.148**	0.03	-.136**
Nursing home enough staff quality care	0.03	-0.04	0.031	-0.046	0.031	-.080**
R^2		0.09		0.118		0.11

† p < .10; * p < .05; ** p < .01. Dummies for education, professional affiliation, and nursing home facility were included in the analysis.

TABLE 3
Regression Analyses for the Effects of RCC on Resident Conflict

	Resident conflict					
Variable	Personal issues with families		How to get work done with families		Resident care issues with families	
Control variables	SE B	B	SE B	B	SE B	B
Age	0.003	-.006‡	0.003	-0.005	0.003	-.008*
Gender	0.113	-0.03	0.112	-0.003	0.111	-0.077
Tenure	0.005	.009‡	0.005	0.007	0.005	0.007
Employment status	0.082	-0.13	0.081	-0.037	0.081	-0.084
Union member	0.118	0.145	0.118	0.204	0.117	0.141
Resident-centered care						
Nursing home resident-centered care	0.055	-0.013	0.055	-0.067	0.054	-0.085
Administration support for resident-directed care	0.047	-.126**	0.047	0.002	0.047	-0.02
Strong emphasis on training	0.037	0.034	0.037	-0.024	0.037	-0.027
Less use of agency staff	0.028	-.097**	0.028	-.151**	0.028	-.127**
Nursing home enough staff quality care	0.029	-0.023	0.029	-0.031	0.029	-0.031
R^2		0.059		0.089		0.074

‡ p < .10; * p < .05; ** p < .01. Dummies for education, professional affiliation, and nursing home facility were included in the analysis.

As seen in Table 3, hypotheses 4 through 6 are also partially supported. With respect to resident conflicts, these hypotheses posit that organizational practices and commitment decrease employees' conflicts with resident families. Our results generally support the direction of the hypotheses, but some RCC practices were found ineffective in reducing conflicts. For example, the hypothesized relationship was found between employee participation in RCC (β = -.126, p < .01) and less use of agency staff (β = -.097, p < .01) and conflicts with families over personal issues. On the other hand, only staffing-associated practices (less use of agency staff and sufficient level of staffing) were effective in reducing resident conflicts over the way work should be done and resident care issues.

Discussion and Conclusion

Summary of Contributions

The primary purpose of our study was to examine the effects of RCC practices in nursing homes on organizational conflicts among employees and conflicts with resident families. One underlying motivation was to extend our understanding of the impacts of high performance work systems (HPWS) by looking at RCC practices—essentially an applied form of HPWS in a health care context—by establishing effects on employee outcomes other than organizational financial performance.

We found positive evidence that RCC practices are negatively related to task conflicts that employees experience with supervisors, within the unit, and with other units. Although the relationships seem to exist particularly with certain practices of RCC— focus on training, less use of agency staff, and sufficient staffing—the results provided general support for the hypothesized impacts of RCC. Our results also suggest that to the extent that nursing home organizations implement RCC practices, employees experience reduced amounts of conflicts with resident families over personal and resident care issues. Similarly, RCC practices addressing staffing issues were found most effective in reducing conflict. The negative relationship between organizational encouragement of employees' participation in RCC and conflicts with families over personal issues was also supported.

It is especially worth noting that staffing-related practices (less use of agency staff and sufficient staffing level) had strong impacts on both types of organizational conflicts. Staffing issues have been extensively discussed by many researchers, who have examined factors enhancing care quality of nursing homes. The importance of having committed staff as well as maintaining appropriate levels of staffing has been emphasized because staffing practices were found directly linked to care quality. Our study provides additional support for the claim that staffing is an important organizational arrangement by showing that staffing practices affect conflicts among employees and conflicts with resident families.

This study makes an important contribution to HPWP literature. The relationship between work practices and organizational outcomes has been studied mostly in the manufacturing sector, and only a few studies have been conducted in health care service settings (Eaton 2000, 2002; Gittell, Seidner, and Wimbush, forthcoming). Many health care organizations, including nursing homes, have been committed to organization-level restructuring efforts to enhance the quality they provide and to change the focus of their service to patients or residents; however, the effects of such initiatives have been only limitedly explored. We provide some evidence as to the impacts of work practices to organizational conflicts and conflicts with residents, with a specific focus on the nursing home setting.

Our study also contributes to conflict research. We examined task conflict—measured as the extent to which employees disagree over resident care issues—and conflicts between employees and resident families that determine the quality of residents' care experience in a nursing home. Thus, we have attempted to understand the broad impacts of conflict within a specific context. Our study also has important implications for conflict management. We focused on conflicts as outcomes of a nursing home's RCC practices; however, the negative relationships between RCC (specifically staffing practices) and conflict imply that many organizational conflicts may have roots in staffing levels and use of agency workers. Task conflicts that employees experience are not necessarily a process looking for an optimal solution in many situations, as some conflict scholars might argue. Organizations can actively take part in managing and reducing organizational conflicts through the implementation of human resource practices and systems.

Limitations

Our study is not without limitations, of course. One of the main weaknesses was the use of a cross-sectional design, which does not allow for an assessment of the impact of cause and effect. Another limitation relates to the source of data. The data are not free from the potential effects of common source bias because evaluations of RCC practices and two types of conflicts both came from the same rater source (i.e., employees). Future research thus might want to include ratings of RCC collected from human resource departments rather than employees or collect resident conflicts from residents or resident families. The third limitation concerns the issue of generalizability. We studied a sample of nursing home employees in one metropolitan region. Future research needs to include a broader sampling of organizations across different regions. Finally, it will be very meaningful if similar studies in nursing home settings take into account some resident outcomes. Specifically, if organizational conflicts among employees and conflict between employees and residents are employed as a mediating process of the relationship between RCC and resident satisfaction, and empirical evidence is provided, it will be a more complete explanation of the effects of RCC.

Conclusion

In perhaps the most well-regarded study of the historical origins of modern medicine, Rosenberg (1987:8) claims that the professionalization of nursing is "the most important single element in reshaping" the delivery of health care. Our study seems to add empirical weight to this claim. Clearly, our results suggest that staffing practices, such as having highly committed health care delivery employees and maintaining adequate staffing levels, are important components of RCC. Additionally, innovative work systems not only ensure that resident needs are successfully met but also help to prevent potentially harmful conflicts and tensions within the organization. We believe that the implementation of RCC initiatives provides a work environment that opens the potential for compassionate professionals to deliver a higher quality health care experience.

References

Agarwala, Tanuja. 2003. "Innovative Human Resource Practices and Organizational Commitment: An Empirical Investigation." *International Journal of Human Resource Management*, Vol. 14, No. 2, pp. 175–97.

Aiken, Linda H., Sean P. Clarke, and Douglas M. Sloane. 2002. "Hospital Staffing, Organization, and Quality of Care: Cross-National Findings." *International Journal for Quality in Health Care*, Vol. 14, No. 1, pp. 5–13.

Amason, Allen C. 1996. "Distinguishing the Effects of Functional and Dysfunctional Conflict on Strategic Decision Making: Resolving a Paradox for Top Management Teams." *Academy of Management Journal*, Vol. 39, No. 1, pp. 123–48.

Amason, Allen C., and David Schweiger. 1997. "The Effect of Conflict on Strategic Decision Making Effectiveness and Organizational Performance." In Carsten K.W. De Dreu and Evert Van de Vliert, eds., *Using Conflict in Organizations*. London: Sage, pp. 101–15.

Appelbaum, Eileen, Thomas Bailey, Peter Berg, and Arne L. Kalleberg. 2000. *Manufacturing Advantage: Why High-Performance Work Systems Pay Off*. Ithaca, NY: Cornell University Press.

Aspden, Philip, Julie A. Wolcott, J. Lyle. Bootman, and Linda R. Cronenwett. 2007. *Preventing Medication Errors*. Institute of Medicine Report on Medical Errors. Washington, DC: National Academy Press.

Avgar, Ariel C. 2009. *After the Storm: Healthcare Restructuring, Conflict and Its Resolution in Hospitals*. Paper presented at the annual meeting of the Academy of Management, Chicago.

Avgar, Ariel C., Rebecca K. Givan, and Mingwei Liu. 2009. *Patient Centered But Employee Delivered: Patient Care Restructuring, Turnover, and Organizational Outcomes in Hospitals*. Paper under review.

Bae, Jongseok, and John J. Lawler. 2000. "Organizational and HRM strategies in Korea: Impact on Firm Performance in an Emerging Economy." *Academy of Management Journal*, Vol. 43, No. 3, pp. 502–17.

Batt, Rosemary. 2002. "Managing Customer Services: Human Resource Practices, Quit Rates, and Sales Growth." *Academy of Management Journal*, Vol. 45, No. 3, pp. 587–97.

Bergeson, Steven C., and John D. Dean. 2006. "A Systems Approach to Patient-Centered Care." *Journal of the American Medical Association,* Vol. 296, No. 23, pp. 2848–51.

Bostick, Jane E. 2004. "Relationship of Nursing Personnel and Nursing Home Care Quality." *Journal of Nursing Care Quality*, Vol. 19, No. 2, pp. 130–36.

Davis, Karen, Stephen C. Schoenbaum, and Anne-Marie Audet. 2005. "A 2020 Vision of Patient-Centered Primary Care." *Journal of General Internal Medicine*, Vol. 20, No. 10, pp. 953–57.

De Dreu, Carsten K.W. 2008. "The Virtue and Vice of Workplace Conflict: Food for (Pessimistic) Thought." *Journal of Organizational Behavior*, Vol. 29, No. 1, pp. 5–18.

De Dreu, Carsten K.W., and Bianca Beersma. 2005. "Conflict in Organizations: Beyond Effectiveness and Performance." *European Journal of Work and Organizational Psychology*, Vol. 14, No. 2, pp. 105–17.

De Dreu, Carsten K W., and Allenies E.M. Van Vianen. 2001. "Managing Relationship Conflict and the Effectiveness of Organizational Teams." *Journal of Organizational Behavior*, Vol. 22, No. 3, pp. 309–28.

De Dreu, Carsten K.W., and Laurie R. Weingart. 2003. "Task Versus Relationship Conflict, Team Performance, and Team Member Satisfaction: A Meta-Analysis." *Journal of Applied Psychology*, Vol. 88, No. 4, pp. 741–9.

Eaton, Susan C. 2000. "Beyond 'Unloving Care': Linking Human Resource Management and Patient Care Quality in Nursing Homes." *International Journal of Human Resource Management,* Vol. 11, No. 3, pp. 591–616.

Eaton, Susan C. 2002. *What a Difference Management Makes! Nursing Staff Turnover Variation within a Single Labor Market. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Report to Congress, Phase II*. Released June 12 by the Center for Medicare and Medicaid Services.

Ford, Robert C., and Myron D. Fottler. 2000. "Creating Customer-Focused Health Care Organizations." *Health Care Management Review*, Vol. 25, No. 4, pp. 18–33.

Garman, Andrew N., Ann S. McAlearney, Michael I. Harrison, Paula H. Song, Dina Moss, and Megan McHugh. 2009. *High Performance Work Practices in Healthcare Management: An Evidence-Based Review and Synthesis*. Paper presented at the annual meeting of the Academy of Management, Chicago.

Gittell, Jody H., Rob Seidner, and Julian Wimbush. Forthcoming. "A Relational Model of How High-Performance Work Systems Work." *Organization Science*.

Glass, Anne P. 1991. "Nursing Home Quality: A Framework for Analysis." *Journal of Applied Gerontology*, Vol. 10, No. 1, pp. 5–18.

Hegland, A. 1990. "Nip Patient Abuse in the Bud: Aides Tackle Conflict Resolution." *Contemporary Long-Term Care*, Vol. 13, No. 9, pp. 64, 113.

Hudson, B. 1992. "Ensuring an Abuse-Free Environment: A Learning Program for Nursing Home Staff." *Journal of Elder Abuse and Neglect*, Vol. 4, No. 4, pp. 25–36.

Huselid, Mark A. 1995. "The Impact of Human Resource Management Practices on Turnover, Productivity, and Corporate Financial Performance." *Academy of Management Journal*, Vol. 38, No. 3, pp. 635–72.

Ichniowski, Casey, Kathryn Shaw, and Giovanna Prennushi. 1997. "The Effects of Human Resource Management Practices on Productivity: A Study of Steel Finishing Lines." *American Economic Review*, Vol. 87, No. 3, pp. 291–313.

Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.

Janssen, Onne, Evert Van de Vliert, and Christian Veenstra. 1999. "How Task and Person Conflict Shape the Role of Positive Interdependence in Management Teams." *Journal of Management*, Vol. 25, No. 2, pp. 117–42.

Jehn, Karen A. 1995. "A Multi-Method Examination of the Benefits and Detriments of Intragroup Conflict." *Administrative Science Quarterly*, Vol. 40, No. 2, pp. 256–82.

Jehn, Karen A., and Elizabeth A. Mannix. 2001. "The Dynamic Nature of Conflict: A Longitudinal Study of Intragroup Conflict and Group Performance." *Academy of Management Journal*, Vol. 44, No. 2, pp. 238–51.

Kayser-Jones, Jeanie. 1997. "Inadequate Staffing at Mealtime: Implications for Nursing and Health Policy." *Journal of Gerontology Nursing*, Vol. 23, No. 8, pp. 14–21.

Kayser-Jones, J., and Ellen Schell. 1997. "The Effect of Staffing on the Quality of Care at Mealtime." *Nursing Outlook*, Vol. 45, No. 2, pp. 64–72.

Kohn, Linda. T., Janet M. Corrigan, and Mollas S. Donaldson. 2000. *To Err Is Human: Building a Safer Health System.* Institute of Medicine Report on Medical Errors. Washington, DC: National Academy Press.

Lauver, Diane R., Sandra E. Ward, Susan M. Heidrich, Mary L. Keller, Barbara J. Bowers, Patricia F. Brennan, Karin T. Kirchhoff, and Thelma J. Wells. 2002. "Patient-Centered Interventions." *Research in Nursing and Health*, Vol. 25, No. 4, pp. 246–55.

Lee, Shoou-Yih D., and Jeffrey, A. Alexander. 1999. "Managing Hospitals in Turbulent Times: Do Organizational Changes Improve Hospital Survival?" *Health Services Research*, Vol. 34, No. 4, pp. 923–46.

Macky, Keith, and Peter Boxall. 2007. "The Relationship Between 'High-Performance Work Practices' and Employee Attitudes: An Investigation of Additive and Interaction Effects." *International Journal of Human Resource Management*, Vol. 18, No. 4, pp. 537–67.

Mead, Nicola, and Peter Bower. 2000. "Patient-Centeredness: A Conceptual Framework and Review of the Empirical Literature." *Social Science and Medicine*, Vol. 51, No. 7, pp. 1087–110.

Nelson, H. Wayne, and Donna M. Cox. 2003. "The Causes and Consequences of Conflict and Violence in Nursing Homes: Working Toward a Collaborative Work Culture." *The Health Care Manager*, Vol. 22, No. 1, pp. 85–96.

Osterman, Paul. 1994. "How Common Is Workplace Transformation and How Can We Explain Who Does It?" *Industrial and Labor Relations Review*, Vol. 47, No. 2, pp. 173–88.

Pfeffer, Jeffrey. 1994. *Competitive Advantage Through People: Unleashing the Power of the Work Force.* Boston: Harvard Business School Press.

Piore, Michael J., and Charles F. Sabel. 1984. *The Second Industrial Divide: Possibilities for Prosperity.* New York: Basic Books.

Rantz, Marilyn J., David R. Mehr, Lori Popejoy, Mary Zwygart-Stauffacher, Lanis L. Hicks, Victoria Grando, Vicki S. Conn, Pose Porter, Jill Scott, and Meridean Maas. 1998. "Nursing Home Care Quality: A Multidimensional Theoretical Model." *Journal of Nursing Care Quality,* Vol. 12, No. 3, pp. 30–46.

Rosenberg, Charles E. 1987. *The Care of Strangers: The Rise of America's Hospital System.* New York: Basic Books.

Simons, Tony L., and Randall S. Peterson. 2000. "Task Conflict and Relationship Conflict in Top Management Teams: The Pivotal Role of Intragroup Trust." *Journal of Applied Psychology*, Vol. 85, No. 1, pp. 102–11.

Starr, Paul. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

West, Michael A., Carol S. Borrill, Carol, Jeremy Dawson, Judy Scully, Mathew Carter, Stephen Anelay, Malcolm Patterson, and Justin Waring. 2002. "The Link Between the Management of Employees and Patient Mortality in Acute Hospitals." *International Journal of Human Resource Management,* Vol. 13, No. 8, pp. 1299–310.

West, Michael A., James P. Guthrie, Jeremy Dawson, Borrill, Carol, and Mathew Cater. 2006. "Reducing Patient Mortality in Hospitals: The Role of Human Resource Management." *Journal of Organizational Behavior*, Vol. 27, No. 7, pp. 983–1002.

Wolf, Debra M., Lisa Lehman, Robert Quinlin, Thomas Zullo, and Leslie Hoffman. 2008. "Effect of Patient-Centered Care on Patient Satisfaction and Quality of Care." *Journal of Nursing Care Quality*, Vol. 23, No. 4, pp. 316–21.